LeMoine Physical Therapy

MEDICARE PATIENT & PAYOR INFORMATION (Please Print)

1) Patient Information – All Patient or Patient's Legal Representative, please complete all sections

Patient Name (Last, First, M) –Full Legal Name or as on Insurance Card	Sex	Marital Status	Date of Birth	Social Security No.

Street Address	City, State, Zip	Mobile Phone
Employer	Employer Address	Home Phone
Email Address		Work Phone

2) Other Information

Referring Doctor (Name, Location)	Phone:
Family Doctor (Name, Location)	Phone:

Emergency Contact	Cell Phone	Work Phone

3) Why did you choose LeMoine Physical Therapy? (select ONE answer only)?

☐ Doctor	☐ I'm a Returning Patient	☐ Google Maps/Reviews
☐ My Insurance	☐ Social Media (Instagram or Twitter)	☐ Facebook
☐ Friend or family	☐ Other:	☐ Yelp!
☐ Walked by/in	_____	☐ General Online Search

4) Conditions to be Treated in Physical Therapy

Are you currently receiving Home Health? ☐ Yes ☐ No (i.e. any healthcare worker, aid assisting or doing something for you?)	☐ If Yes, From Who?
Do you live in a nursing home? ☐ Yes ☐ No	☐ If Yes, What is it's Name?
Are you Covered by Group Insurance?) ☐ Yes ☐ No	☐ If Yes, Name: _____ Group: _____

5) Payor Insurance Information Primary

Primary Insurance Company: **Medicare**

Ins. Co. Name:_____ Insured's Name:_____ Ins. Phone:_____

Patient ID #: _____ Group. #: _____ Policy/Plan #: _____

Regular Medicare: ☐ Yes ☐ No Rail Road Medicare: ☐ Yes ☐ No

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6) Payor Information Secondary/Supplementary Insurance Company: (If YES, please complete)

Ins. Co. Name:_____ Insured's Name:_____ Ins. Phone:_____

Insured is: ☐ Patient ☐ Spouse ☐ Parent

Patient ID #: _____ Group. #: _____ Policy/Plan #: _____

Employer Name: _____ Employer Phone #: _____

Address: _____ City: _____ State: _____ Zip:_____

7) Credit Card Payment Authorization

I hereby authorize LeMoine Physical Therapy to charge my credit card for services rendered until this authorization is revoked by me. It is my responsibility to notify LeMoine Physical Therapy any changes regarding this credit card authorization.

Name on Card	Signature / Date	
Credit Card Type ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover	Credit Card Number	
Expiration Date	Security Code	Billing Zip Code

8) Payment Authorization: (Initials required for all 3 statements)

_____
Initials

Assignment of Insurance Benefits
I Authorize that the payment of my insurance benefits be made directly to LeMoine Physical Therapy for all services delivered; if I am paid directly I will promptly pay LeMoine Physical Therapy all monies paid to me.

_____
Initials

Guarantee of Payment
I understand that all payments designated as 'the patient's responsibility' such as co-insurance and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed 'my responsibility' by my insurer by the statement due date.

_____
Initials

Certification of Information
I certify that the information I have provided LeMoine Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

9) I attest, to the best of my knowledge, the above information is accurate and true

Signature/ Date: _____

_____ _____

Patient or Legal Representative's Signature **Today's Date**

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CONSENT FOR CARE AND TREATMENT
I the undersigned, having legal authority to do so, do hereby agree and give consent for LeMoine Physical Therapy to furnish medical care and treatment to as considered necessary and proper in diagnosing or treating my/his/her condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION
I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled, to LeMoine Physical Therapy. A photocopy of this assignment is to be considered as valid as the original. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to LeMoine Physical Therapy, Inc. within five (5) days of receipt of such payment.

I hereby authorize the release of all information necessary, including Medical Records, to secure payment.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL LEMOINE PHYSICAL THERAPY SERVICES:
I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, LeMoine Physical Therapy Inc. will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for LeMoine Physical Therapy Inc. to take action to secure payment of an outstanding balance owed.

SCHEDULING AND CANCELLATION POLICY
LeMoine Physical Therapy urges you to keep every appointment, as consistent treatment will expedite your recovery. In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Saturday and Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a $30.00 charge for each occurrence. Arrival more than 30 minutes after the time of your scheduled appointment may be considered a failed appointment.

ACKNOWLEDGEMENT OF OFFER OF NOTICE OF PRIVACY PRACTICES _ _____**Initials**

NO GUARANTEES: I recognize that the practice of physical therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy rendered at LeMoine Physical Therapy, Inc.

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my therapist the nature and purpose of Physical Therapy treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the Physical Therapy treatments offered or recommended to me by my Doctor and/or Physical Therapist. I intend this consent to apply to all my present and future Physical Therapy care.

Patient Print Name: _____ Date _____

Patient's Signature: _____ Date _____

Guardian/ Responsible Party: _____ Date _____

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Health History (Please Print)

Patient Name (Last, First, MI)	Age:	Height:	Weight:	Today's Date

Do you have a pacemaker? Yes No	Do you smoke? Yes No	Are you latex sensitive? Yes No

ALLERGIES:

MEDICATIONS (include pills, injections and/or skin patches):

Have you ever taken steroid medications for any medical conditions? **Yes** **No**

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **Yes** **No**

SURGERIES, INJURIES, AND HOSPITALIZATIONS:

Diagnostic Tests (for example: x-ray, MRI, CT Scan, Bone Scan, blood tests):

Treatment received so far for this injury, pain, or problem:

Occupation, including activities that comprise your work day:

Are you on a work restriction from your doctor? **Yes** **No** If yes, explain:

Leisure activities, including exercise:

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? Yes No

Have you RECENTLY experienced any of the following (check all that apply)?

☐ Fatigue	☐ Numbness or tingling	☐ Constipation
☐ Fever/chills/sweats	☐ Muscle weakness	☐ Diarrhea
☐ Nausea/vomiting	☐ Dizziness/lightheadedness	☐ Shortness of breath
☐ Weight loss/gain	☐ Heartburn/indigestion	☐ Fainting
☐ Difficulty maintaining balance while walking	☐ Difficulty swallowing	☐ Cough
☐ Falls	☐ Changes in bowel or bladder function	☐ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ AIDS / HIV	☐ Depression	☐ Thyroid problems
☐ Cancer	☐ Lung problems	☐ Diabetes
☐ Heart problems	☐ Tuberculosis	☐ Osteoporosis
☐ Chest pain/angina	☐ Asthma	☐ Multiple sclerosis
☐ High blood pressure	☐ Rheumatoid arthritis	☐ Epilepsy / Seizures
☐ Circulation problems	☐ Other arthritic condition	☐ Eye problem/infection
☐ Blood clots	☐ Bladder/urinary tract infection	☐ Ulcers
☐ Stroke	☐ Kidney problem/infection	☐ Liver problems
☐ Anemia	☐ Sexually transmitted disease	☐ Hepatitis
☐ Bone or joint infection	☐ Pelvic inflammatory disease	☐ Pneumonia
☐ Chemical dependency (i.e., alcoholism, recreational drugs)		

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Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?		
☐ Cancer ☐ Heart problems ☐ High blood pressure	☐ Diabetes ☐ Stroke ☐ Depression	☐ Tuberculosis ☐ Thyroid problems ☐ Blood clots

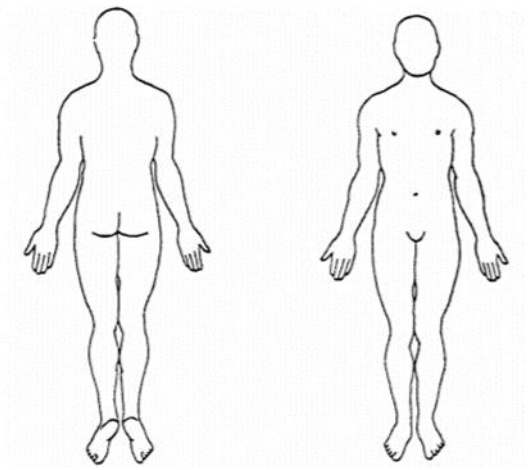
Approximately what date did your symptoms start (include surgery date if applicable)?

What do you think caused your symptoms, injury and/or pain?

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

Aggravating Factors: Can you identify positions or activities that make your symptoms worse?

1)

2)

3)

Symptom relieving Factors: Can you identify positions or activities that make your symptoms better?

1)

2)

3)

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "emergency room pain" please describe:
Your current level of pain while completing this survey: _____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____

Have you ever had this injury before: ❑ Yes ❑ No When_____ Treatment rec'd_____

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ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for LeMoine Physical Therapy, Inc. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to LeMoine Physical Therapy, Inc. to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name Date

_____

Patient's or Authorized Representative's Signature

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE FEEL FREE TO SPEAK TO YOUR THERAPIST, HIS/HER DESIGNEE OR THE HIPAA PRIVACY OFFICER.

LeMoine Physical Therapy, Inc. is committed to maintaining and protecting the confidentiality of your personal information. This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It will inform you about the ways in which we may use and disclose your health information, and the safeguards we have put into place to protect it. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

OUR DUTIES TO YOU REGARDING YOUR PROTECTED HEALTH INFORMATION

"Protected Health Information" is individually identifiable health information expressed in the form of oral, written or electronic communications. This information includes demographic information such as your age, address, email address, and other information that relates to your past, present or future health condition and related healthcare services. LeMoine Physical Therapy, Inc. is required by law to:

- Make sure your health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in this notice to you.

GOVERNMENTAL PRIVACY LAWS AND REGULATIONS

There are several other federal, state and city privacy laws that provide stronger restrictions about the use and disclosure of health information. The stricter laws have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information. We will not use your confidential information or disclose it to others without your authorization, except for the following purposes:

Treatment. We may use and/or disclose your confidential health information to provide you with treatment and/or services. This includes your therapist's recommendation(s), and those of other professionals/paraprofessionals including clerical, coordination and management staff.

Payment. Your protected health information will be used, as needed, to bill and collect payment for treatment and services provided to you. We may share information about a treatment and/or service you may receive to your health insurer to receive approval for payment.

Health Care Operations. We may use and disclose health information about you for regular health care operations. The medical staff in this practice will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality assessment/improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

We will share your protected health information with third-party "business associates" who perform various activities for the practice. The business associates will also be required to protect your health information. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning your identity.

Appointment Reminders. We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or care in our Practice. These reminders will not identify the purpose of your visit.
Required by Law. We will disclose health information about you when required to do so by federal, state or local laws.
Public Health Activities. We may disclose your confidential health information for the following public health activities and purposes:

- To report health information to public health authorities that are authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability;
- To report child abuse or neglect to a government authority that is authorized by law to receive such reports;
- To report information about a product or activity that is regulated by the US Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
- To conduct post-marketing surveillance, as required; and
- To alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this notice.

Legal Proceedings. We may release protected health information about you in response to a court or administrative order if you are involved in a lawsuit or dispute. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release health information if asked to do so by law enforcement officials: • In response to a court order, subpoena, warrant, summons or similar process. • To identify or locate a suspect, fugitive, material witness or missing person. • About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement. • About the death we believe may be the result of criminal conduct. • About criminal conduct at the Practice. • In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Research. Under certain circumstances, we may use and disclose your confidential information for research purposes without an authorization. An authorization would not be necessary if your identifying information was removed.
Workers' Compensation. We may release your health information to comply with Workers' Compensation Laws and other similar legally established programs. The programs provide benefits for work-related illness or injury.

Promotional Gifts. We may use your confidential health information so that we may provide you with nominal gifts. We will not disclose your confidential information to other companies for their marketing purposes.

Health Related Benefits and Services. We may use and disclose health information to inform you about health-related benefits or services that may be of interest to you. You may be contacted by the Practice regarding general health-related products and services and/or health-related products and services targeted to your specific health status or condition, but only where we believe those products or services may benefit you. If the communication is targeted to you, it must explain why you were targeted and how the product or service relates to your health. Any communication you receive must identify the Practice as the source of the communication, inform you if we received any payment for making the communication and contain instructions about how you may request that we not contact you further about such health related products and services.

Criminal Activity. Under certain Federal and state laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Government Functions. We may disclose your health information to the U.S. Military or to authorized federal or state officials for purposes specified by federal law.

Coroners, Funeral Directors, and Organ Donation. We may disclose your health information to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also disclose protected health information to funeral directors as authorized by law to assist them in carrying out their duties. Protected health information may also be used and disclosed for organ eye and tissue donations if you have previously agreed to organ donation.

Parental Access. Various Maryland State laws determine what protected health information can be disclosed to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law and will make disclosures only when necessary.

Individuals Involved in Your Care. Unless you object, we may use or disclose your health information to notify or assist in the notification of a family member or personal representative of your location, your general condition, or death. If you are present, you will have the opportunity to object to this type of use or disclosure. If you are unable to decide or if it is an emergency, we may disclose information that is directly relevant to the person's involvement in your healthcare, if we determine that it is in your best interest to do so.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Although your health record is the physical property of LeMoine Physical Therapy, Inc., the information belongs to you. You have the following rights regarding your protected health information. You may make any of the following requests by completing a "HIPAA Patient Rights Request Form" or by submitting a written request to our office.

Right to Inspect and Copy. You have the right to both inspect and obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain your health information. This information is used to make health-related decisions about your care and typically includes professional treatment/progress notes, supplement programs, laboratory reports, prescriptions, and billing/financial records. This request does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to laws that prohibit access. If you request copies, we may charge you copying and mailing costs. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. While we consider all requests for restrictions carefully, we are not required to agree to your request.

Right To Request Amendment. If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for LeMoine Physical Therapy, Inc., if we determine the record is inaccurate. We may deny your request if it is not in the appropriate form or does not include a reason to support the request. In addition we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information kept by or for LeMoine Physical Therapy, Inc.
- Is not part of the information which you would be permitted to inspect or copy
- Is accurate and complete

Right to Request Confidential Communications. You may request that we communicate with you using alternative means or at an alternative location. You may also ask that we mail information to you in a sealed envelope rather than a postcard. While we will consider this request carefully, we are not required to agree to all requests.

Right to Request an Accounting of Disclosures. You have the right to an accounting of disclosures. This is a list of where we have sent your protected health information that does not include disclosures made for treatment, payment, or healthcare operations as described in this notice. Your request must state a time period beginning on or after April 14, 2003, and no more than 6 years from the date of request.

Right To Obtain a Copy of this Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. To obtain a copy of this, please contact the Practice Administrator or his/her designee.

CHANGES TO THIS NOTICE We reserve the right to change our privacy practices and this notice. We reserve the right to make changed notice effective for health information we already have about you as well as any information we receive in the future. If we change the notice, we will provide each active patient with a new notice. You may also obtain a new notice by calling our office.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with LeMoine Physical Therapy, Inc.'s Privacy Officer or his/her designee at the address below. No retaliation will occur against you for filing a complaint. All complaints must be submitted in writing. You may also file written complaints with the Secretary of the US Department of Health and Human Services. Please call our office to obtain the correct address for the Secretary.

LeMoine Physical Therapy
HIPAA Privacy Officer
1232 Race Road Ste. 203
Baltimore, MD 21237

OTHER USES OF YOUR HEALTH INFORMATION Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your permission and we are required to maintain in our records of the care that we provided to you.

This notice was published on January 5, 2009 and all provisions become effective by Federal Law on April 14, 2003. Our Notice of Privacy Practices remain in effect until modified by LeMoine Physical Therapy.